U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 27 December 2006

In the Matter of:

C.C., Case No.: 1994-BLA-01240
Claimant

v.

WESTMORELAND COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Robert F. Cohen
Cohen, Abate, & Cohen, L.C.
Morgantown, West Virginia
For the Claimant

Kathy L. Snyder and Douglas Smoot
Jackson & Kelly PLLC
Morgantown, West Virginia
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER ON THIRD REMAND AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq.* The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and the regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis. The case is before me on remand from the Benefits Review Board.

PROCEDURAL HISTORY

The Initial Claim

The Claimant filed a claim for black lung benefits on January 28, 1980. DX 33 (DX 1).[1] The District Director of the Office of Workers Compensation Programs ("OWCP") awarded benefits on October 15, 1980. In the initial award, McKenzie Mining Company was named as the responsible operator. DX 33 (DX 24). McKenzie Mining Company filed for Chapter 7 bankruptcy; its bankruptcy case was determined to be a "no asset" case. DX 33 (DX 34, 75). Upon this finding, on April 6, 1987, the District Director issued an Amended Notice of Initial Finding, naming Westmoreland Coal Company ("Westmoreland") as the responsible operator. DX 33 (DX 36). Westmoreland timely filed a controversion to the initial finding. On July 2, 1987, the District Director issued an initial determination, which again found that the Claimant was eligible for benefits, and that Westmoreland was the responsible operator. DX 33 (DX 43). Westmoreland requested a hearing, and the claim was referred to the Office of Administrative Law Judges ("OALJ") on July 16, 1987. DX 33 (DX 44, 45).

As part of the proceedings before OALJ, Westmoreland moved to dismiss itself as the responsible operator (DX 33 (DX 68)), whereupon the Director, OWCP, moved for a remand to further develop the issue (DX 33 (DX 71)). A hearing went forward during which the Employer's and the Director's Exhibits were admitted into evidence, but after discussion of the pending motions, the Administrative Law Judge ("ALJ" or "the Judge") remanded the claim. DX 33 (DX 72, 73). After additional investigation of the ability of McKenzie Mining Company to pay benefits, the case was returned to OALJ with Westmoreland again named as the responsible operator. DX 33 (DX 75-80). The case was then assigned to ALJ Chao, who held another hearing in May 1990, admitting additional Employer's and Director's Exhibits, and taking testimony.

On July 5, 1990, Judge Chao issued a Decision and Order Denying Benefits. Judge Chao found that Westmoreland was properly named as the responsible operator. He denied benefits, however, on the ground that the Claimant had invoked the presumption of total disability due to pneumoconiosis under 20 CFR Part 727 with a qualifying pulmonary function study, but had not established that he had pneumoconiosis, and "[s]ince none of the medical reports found a totally disabling pulmonary impairment," Decision and Order at 3, the presumption had been rebutted. The Claimant appealed this decision to the Benefits Review Board ("BRB" or "the Board"), which dismissed the Claimant's appeal as untimely. The Claimant then submitted a petition for modification to the District Director, who denied the petition on October 11, 1991. DX 33. The Claimant took no further action on his initial claim.[2]

[1] In this Decision, "DX" refers to the Director's Exhibits, "CX" refers to the Claimant's Exhibits, "EX" refers to the Employer's Exhibits, and "Tr." refers to the transcript of the hearing before Judge Fath held on February 14, 1995.

[2] The BRB specifically held that the 1980 claim is no longer viable in its April 29, 2004, Decision and Order at p. 3.

The Duplicate Claim

This claim has an extensive procedural history. It has now been remanded three times by the BRB. In its most recent decision, the Board affirmed in part and vacated in part the most recent decision by an ALJ, and required the Judge on remand to: (1) determine whether the record should be reopened to admit additional medical evidence; and, (2) with or without new evidence, reweigh the medical evidence pursuant to 20 CFR § 718.202(a)(4) to determine whether there is sufficient evidence for a finding of pneumoconiosis, in accordance with the standard enunciated in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000). In order to understand the current posture of the case, it is necessary to review the procedural history in detail.

Judge Fath's Decision and the First Remand

On July 27, 1993, the Claimant filed the instant duplicate claim. DX 1. Initially, on January 6 1994, the District Director awarded benefits. Westmoreland requested a hearing, and the claim was referred to OALJ. During the proceedings before ALJ Fath, the Claimant filed a motion to compel discovery of medical reports prepared by experts retained by the Employer, which the Employer did not intend to introduce at the hearing. Judge Fath denied the Claimant's motion. Also during the proceedings before Judge Fath, Westmoreland filed a motion to dismiss itself as the responsible operator. The parties stipulated that the Claimant had worked for 30 years in the coal mining industry. Tr. at 30. In his Decision and Order issued on September 12, 1995, Judge Fath held that the responsible operator issue was not subject to review and reaffirmed Judge Chao's finding that Westmoreland is the proper responsible operator. Judge Fath denied benefits, finding that the Claimant failed to establish the existence of pneumoconiosis under 20 CFR § 718.202(a), and thus, failed to establish a material change in conditions pursuant to 20 CFR § 725.309. The Claimant then requested reconsideration of his claim, which Judge Fath summarily denied on January 19, 1996.

The Claimant appealed Judge Fath's Denial of Benefits and Denial of Reconsideration. The BRB allowed the appeal and issued a Decision and Order on October 17, 1997. This Decision and Order vacated Judge Fath's decision denying benefits, and his order denying the Claimant's motion to compel discovery of the Employer's nontestifying expert reports. The Board remanded the case with instructions to reconsider whether the Claimant should be allowed to obtain the medical evidence which the Employer had withheld. Additionally, the BRB directed the ALJ to make a finding on the issue of material change in conditions, holding that Judge Chao's finding that the presumption had been rebutted was a finding that total respiratory disability had not been established. Lastly, the BRB noted that if the ALJ awarded benefits, then the ALJ must address the responsible operator issue.

Judge Kichuk's First Decision and the Second Remand

On remand, the case was assigned to ALJ Kichuk. Judge Kichuk granted the Claimant's Motion to Compel Discovery and, over the objections of the Employer, admitted additional evidence (CX 18-29) obtained by the Claimant as a consequence of the ruling on the motion to compel. On April 14, 1999, Judge Kichuk issued a Decision and Order on Remand Denying Benefits. Judge Kichuk found that the evidence developed since the denial of the Claimant's prior claim established that he suffered from a totally disabling respiratory or pulmonary

impairment (based on medical opinion evidence), and thus, demonstrated a material change in conditions. However, he also found that the entire record did not support the existence of pneumoconiosis. As a result, Judge Kichuk denied benefits and found it unnecessary to address the responsible operator issue. On May 14, 1999, the Claimant requested reconsideration, which Judge Kichuk denied.

Thereafter, the Claimant appealed Judge Kichuk's decision. The BRB allowed the appeal and, in a Decision and Order dated April 13, 2001, vacated Judge Kichuk's Decision and Order on Remand. Specifically, the BRB held that it was not clear whether Judge Kichuk had addressed whether the Claimant's obstructive lung disease constituted pneumoconiosis under the Act, so it vacated and remanded the decision to clarify that issue. The Board affirmed Judge Kichuk's findings that the Claimant had established that he was totally disabled by a pulmonary or respiratory impairment and, as a result, had also established a material change in conditions. The Board also affirmed Judge Kichuk's finding that the Claimant had not established the existence of pneumoconiosis by virtue of the x-ray readings.

Judge Kichuk's Second Decision and the Third Remand

On November 19, 2002, Judge Kichuk issued a Decision and Order on Second Remand Denying Benefits. He concluded, after examining each medical report to determine if it was documented, reasoned, supported by the objective medical evidence, and rendered by a Board-certified physician, that the Claimant had failed to establish the existence of pneumoconiosis as defined by the Act. As a result, he again denied benefits.

On December 20, 2002, the Claimant requested reconsideration. Additionally, the Claimant filed a Motion to Reopen the Record to admit the report of Dr. Jerome F. Wiot dated December 20, 2002. On February 11, 2003, Judge Kichuk issued a Decision and Order denying the Claimant's request for reconsideration and denying the Motion to Reopen the record.

The Claimant appealed this Decision, and the employer cross-appealed. The BRB heard the appeal and issued its Decision and Order on April 29, 2004. The BRB vacated Judge Kichuk's denial of Claimant's Motion to Reopen the Record and remanded the claim to OALJ for further consideration. Specifically, the BRB held that if the ALJ should find the record to be incomplete or inconclusive on the issue of whether the Claimant has pneumoconiosis, then the ALJ might reopen the record for additional medical evidence at his or her discretion. Additionally, the BRB vacated Judge Kichuk's finding that the medical opinion evidence was insufficient to establish pneumoconiosis under § 718.202(a)(4), because Judge Kichuk "apparently found that the x-ray evidence, which relates to the existence of medical pneumoconiosis, was dispositive in evaluating the medical opinion evidence on the issue of legal pneumoconiosis," a flawed analysis resulting in error in the Decision. The Board instructed the ALJ on remand to weigh the relevant evidence together in accordance with the standard set on in *Compton*. On remand, as Judge Kichuk is no longer available, the case was assigned to me.

Proceedings Before OALJ on the Third Remand

The Claimant's First Motion to Reopen the Record

The Claimant submitted a Motion to Reopen Record to admit Dr. Wiot's December 20, 2002, report into the record. During a telephone conference with the Claimant and the Employer held on February 23, 2005, I found good cause and provisionally granted the Claimant's motion to reopen the record for the limited purpose of admitting Dr. Wiot's report, and any responsive or rehabilitative evidence by the Employer. *See* the transcript of the telephone conference. In that context, the parties requested time to determine whether the x-rays read by Dr. Wiot for his report were still in existence. During a telephone conference held on March 23, 2005, the Employer reported that most of the x-rays were no longer available. The Employer argued that because of this, it should be dismissed as the responsible operator as a matter of due process because crucial evidence was no longer available. I then ruled that I could not go forward without giving the Director an opportunity to participate. Admission of Dr. Wiot's 2002 report was confirmed in the Order dated March 6, 2006, denying the Employer's Motion to Dismiss, described below. The report shall be designated as CX 31.[3]

The Employer's Motion to Dismiss Itself as the Responsible Operator

The Employer filed a Motion to Dismiss itself as the responsible operator on due process grounds. The Claimant agreed that the Employer could be dismissed. The Director, OWCP, opposed the motion. I denied the Motion in an Order dated March 6, 2006, in which I stated:

> Westmoreland Coal Company is the most recent operator which meets the regulatory requirements found at 20 CFR §§ 725.492 and 493 (2000) and has the financial ability to pay benefits. McKenzie Mining Company employed the Claimant after Westmoreland Coal Company. However, McKenzie was dissolved in bankruptcy. Westmoreland and the Claimant contend that McKenzie's directors should have been held responsible for their failure to secure the payment of benefits, and because the District Director, OWCP, failed to pursue McKenzie's directors, the Trust Fund should assume the responsibility for the payment of any benefits awarded in the current claim. The record shows that due to McKenzie's bankruptcy, Westmoreland Coal had been named as the Responsible Operator by the time the Claimant's initial claim was finally closed by the order of the District Director denying benefits on October 11, 1991. The significance, if any, of a failure by the District Director to pursue McKenzie Mining or its directors with respect to the first claim was rendered moot by the denial of benefits, which decision the Benefits Review Board has held was final because the Claimant took no further action on it.
>
> As to the current, duplicate claim, the District Director identified Westmoreland Coal as the Responsible Operator from the outset. Westmoreland has vigorously defended this claim throughout the proceedings. Westmoreland

[3] Judge Fath admitted CX 1-3, and 5-17. Tr. 5-17. Judge Kichuk admitted CX 18-29. Decision and Order on Remand, April 14, 1999. The Claimant offered CX 30, the Curriculum Vitae of Dr. Bassali, under cover of letter dated December 11, 1998, but there is no indication that it was admitted under that number; in any event, it is elsewhere in the record. The next available number, then, is CX 31.

> retained Dr. Wiot to read x-rays and a CT scan of the Claimant's chest. As I view the record, Dr. Wiot's opinion, after he read the CT scan, supported the claim, instead of the defense. Westmoreland attempted to prevent discovery of Dr. Wiot's opinion, and keep it out of evidence. It was only disclosed to the Claimant after the record closed, as a result of the Claimant's appeal. I find that Dr. Wiot's December 20, 2002, report, which clarifies his previous opinions, is new and material evidence. I also find, in light of the procedural history of this case, that the Claimant has shown good cause for submitting it after the record closed. Westmoreland could have had another radiologist read the films in sequence, together with the CT scan, as Dr. Wiot did, while the films were still available, but did not choose to do so. Due process does not require that Westmoreland be excused from potential liability because the films are no longer available.

Thereafter the record was held open to allow the Employer to depose Dr. Wiot. Order dated March 24, 2006.

The Claimant's Second Motion to Reopen the Record

Dr. Wiot was deposed by the Employer on May 18, 2006. The transcript of the deposition was admitted into the record as EX 12. During his deposition, Dr. Wiot stated that he could not determine whether the x-rays and CT scan he had reviewed showed that the Claimant had complicated coal workers' pneumoconiosis, or old tuberculosis. Asked whether there were other radiologic studies which would be helpful in trying to determine the correct diagnosis, Dr. Wiot stated that it might be helpful to compare x-ray films over a substantial period of time, and to perform a high resolution CT scan. On June 26, 2006, the Claimant filed a Motion to Reopen the Record "to Complete [the] Opinion of Dr. Wiot," by having Dr. Wiot review additional chest x-rays from 1994 to 2004, and a CT scan from 2004. The Employer opposed the Motion as exceeding the scope of the purpose of the remand and my previous Order reopening the record to admit Dr. Wiot's 2002 letter, and 2006 deposition. The Employer argued that the Claimant could seek modification if he wants new evidence to be considered. In an order issued on August 8, 2006, I denied the Claimant's Motion "in view of the age of this case and its procedural posture as a remand from the Benefits Review Board," because to have Dr. Wiot consider additional evidence at this stage of the proceedings would open the door for the Employer to have other physicians review the same or different evidence, and, in effect, convert this case into a request for modification. The parties were given 30 days to file closing arguments.

The Employer's Motion to Strike the Claimant's Third Brief on Remand

After requesting and receiving an extension, the Employer timely filed its brief; the Claimant's brief was filed late. The Employer has moved to strike the Claimant's Third Brief on Remand arguing that it falsely argues that the Employer "skewed" the evidence by withholding medical evidence, an argument that was previously addressed by the Benefits Review Board; that citation to and attachment of decisions in the case of *Daugherty v. Westmoreland Coal Co.* was an improper attempt to prejudice the Court; and, that the 81-page brief was filed 12 days late and was too long. The Claimant responds that his argument regarding skewed evidence goes to the weight which should be given to physician opinions given on behalf of the Employer, an issue

not addressed by the Board; that the *Daugherty* case materials were included to show that the Employer's failure to provide certain information to its experts is part of a deliberate pattern, and not inadvertent; and, that the length of the brief was the necessary to assist a new Judge become familiar with the lengthy proceedings and extensive medical evidence in the record of this case. Having considered the arguments of the parties, I find that the Motion to Strike should be denied.

APPLICABLE STANDARDS

This claim relates to a "duplicate" claim filed on July 27, 1993. Because the claim at issue was filed after March 31, 1980, the regulations at 20 CFR Part 718 apply. 20 CFR § 718.2 (2006). Parts 718 (standards for award of benefits) and 725 (procedures) of the regulations underwent extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920, *et seq.* (2000). The Department of Labor has taken the position that as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. *See* 65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19, 2001. 20 CFR § 718.101(b) (2006). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others (including revisions to the rules regarding duplicate claims and modification) do not; for a list of the revised sections which do **not** apply to pending cases, *see* 20 CFR § 725.2(c) (2006). The U.S. District Court for the District of Columbia upheld the validity of the new regulations in *National Mining Association v. Chao*, 160 F.Supp.2d 47 (D.D.C. 2001). However, the Court of Appeals affirmed in part, reversed in part, and remanded the case. *National Mining Association v. Department of Labor*, 292 F.3d 849 (D.C. Cir. 2002) (upholding most of the revised rules, finding some could be applied to pending cases, while others should be applied only prospectively, and holding that one rule empowering cost shifting from a claimant to an employer exceeded the authority of the Department of Labor). On December 15, 2003, the Department of Labor promulgated revisions to 20 CFR §§ 718.2, 725.2, and 725.459 implementing the Circuit Court's opinion. 68 Fed. Reg. 69930, *et seq.* (2003). Accordingly, I will apply only the sections of the newly revised version of Parts 718 and 725 that the Court did not find impermissibly retroactive. In this Decision and Order, the "old" rules applicable to this case will be cited to the 2000 Edition of the Code of Federal Regulations; the "new" rules will be cited to the 2006 Edition.

ISSUES

The issues remanded for determination are:

1. Whether the Claimant's Motion to Reopen the Record should be granted in order to make the evidence more complete or conclusive. I resolved this issue in my orders dated March 6, 2006, and August 8, 2006. Thus the sole issue remaining under the instructions from the Board on remand is:

2. Whether the medical evidence of record is sufficient to establish the existence of pneumoconiosis pursuant to § 718.202(a)(4), weighing the relevant evidence of record together in accordance with the standard enunciated in *Compton*.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Medical Evidence Relevant to a Determination of
Whether the Claimant Has Coal Workers' Pneumoconiosis

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on: (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982), or 718.306 (applicable only to deceased miners); or, (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy and, of course, no autopsy has been performed. The presumptions found in §§ 305 and 306 do not apply because the Claimant filed his claim after January 1, 1982, and he is still living. Some physicians have diagnosed simple and complicated pneumoconiosis and others have not. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions, including the opinions regarding the CT scans. As instructed by the Board, in the face of conflicting evidence, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Compton*, 211 F.3d at 211. As the Board affirmed Judge Kichuk's finding that the Claimant had established a material change in conditions by showing that he was totally disabled by a pulmonary or respiratory condition, I must consider all of the relevant evidence from both claims in reaching my determination whether the Claimant has established that he has pneumoconiosis.

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2000). Any such readings are, therefore, included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column. In addition, one x-ray was found by one reader to be unreadable due to poor quality. That reading has also been listed in the "silent" column.

Physicians' qualifications appear after their names. If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record. Qualifications of physicians are abbreviated as follows: A=NIOSH certified A reader; B=NIOSH certified B reader; BCR=Board-certified in Radiology. Readers who are Board-certified Radiologists

and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n.16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be Radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
04/05/77	CX 1 Goodwin Not classified (Fine nodular fibrosis scattered throughout the lungs due to occupational pneumoconiosis)		
07/02/80	DX 33 Bassali BCR, B 2/2, A CX 11 Zaldivar B 1/1, A	DX 33 Morgan B DX 33 Fino B DX 33 Renn B	
02/05/85	CX 20, EX 12 Wiot BCR, B 1/1, A	DX 33 Fino B DX 33 Morgan B DX 33, EX 1 Renn B EX 3, 10 Wheeler BCR, B EX 2 Scott BCR, B	
06/23/87	CX 3, 29 Bassali BCR, B Unclassified (Diffuse chronic interstitial lung disease presumably due to pneumoconiosis) CX 20, EX 12 Wiot BCR, B 1/1, A	DX 33 Fino B DX 33 Morgan B DX 33, EX 1 Renn B EX 3, 10 Wheeler BCR, B 0/1 EX 3 Scott BCR, B	

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
08/14/87	DX 33 Leef BCR, B 2/1 CX 19 Morgan B 2/1, B CX 18 Duncan BCR, B 1/2, A CX 18 Wershba BCR, B 1/2, A CX 20, EX 12 Wiot BCR, B 1/1, A DX 33 Gogineni BCR, B Unclassified (Nod. changes, could be related to old gran-ulomatous infection, occ. pneumo. or other etiology)	DX 33 Fino B DX 33, EX 1 Renn B DX 33 Morgan B EX 3, 10 Wheeler BCR, B 0/1 EX 3 Scott BCR, B	
12/16/88	DX 31, CX 29 Goodarzi BCR 1/1 DX 20, EX 12 Wiot BCR, B 1/1, A	DX 33 Fino B DX 33, EX 1 Renn B DX 33 Morgan B EX 3, 10 Wheeler BCR, B 0/1 EX 3 Scott BCR, B	
04/19/89	CX 11 Zaldivar B 1/1, A CX 20, EX 12 Wiot BCR, B 1/1, A	EX 7 Fino B EX 1 Renn B EX 3, 10 Wheeler BCR, B 0/1 EX 3 Scott BCR B	CX 28 Renn B Unreadable[4]

[4] It is unclear whether there were two x-rays taken on that date, or Dr. Renn has given two dissimilar readings of one x-ray. In the reading in the "negative" column, he assigned a quality rating of "2". Even if Dr. Renn's negative

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
10/24/91	CX 20, EX 12 Wiot BCR, B 1/1, A CX 25 Bassali BCR, B 2/2 A	EX 1 Renn B EX 3, 10 Wheeler BCR, B 0/1 EX 3 Scott BCR, B	
01/04/92	CX 20, EX 12 Wiot BCR, B 1/1, A CX 24 Bassali BCR, B 1/2, A	EX 1 Renn B EX 3, 10 Wheeler BCR, B 0/1 EX 3 Scott BCR, B EX 9 Fino B	
05/07/92	CX 20, EX 12 Wiot BCR, B 1/1, A	EX 1 Renn B EX 3, 10 Wheeler BCR, B 0/1 EX 3 Scott BCR, B EX 9 Fino B	DX 31, CX 29 Bassali BCR, B (Prominence of bronchovascular markings suggesting bronchitis, smoking or both)
09/08/93	DX 17 Daniel BCR 2/1, A DX 16 Gaziano B 1/1, A CX 21, EX 12 Wiot BCR, B 1/1, A	EX 1 Renn B EX 9 Fino B EX 10 Wheeler BCR, B	
01/05/94	CX 20, EX 12 Wiot BCR, B 1/1, A CX 26 Bassali BCR, B Unclassified (Complicated pneumoconiosis)	EX 3, 10 Wheeler BCR, B 0/1 EX 3 Scott BCR, B	

reading is not considered, the x-ray is still negative, as one B reader and two dually qualified readers found it to be negative, and Dr. Wiot testified at his deposition, EX 12, that despite his positive reading, there is a 50-50 chance that the opacities he observed represent tuberculosis rather than pneumoconiosis.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
05/13/94	CX 20, EX 12 Wiot BCR, B 1/1, A	EX 2 Renn B EX 3, 10 Wheeler BCR, B 0/1 EX 3 Scott BCR, B EX 9 Fino B	
09/19/94	CX 5 Patel BCR, A 2/2, A CX 16 Alexander BCR, B 2/1, A	EX 6, 10 Wheeler BCR, B 0/1 EX 6 Scott BCR, B EX 9 Fino B	

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991). The record in this case contains reports of multiple readings of a CT scan of the Claimant's chest taken on May 13, 1994, at the request of Dr. Renn.

The Radiologist who took the CT scan, Dr. Marano, described a 6 cm mass in the right lung, and a 2.8 cm mass in the left lung, with radiating strands from both. There were fatty-like nodules on the right side. There were calcifications in within the masses. Bullae were present within both apices. Dr. Marano did not specify any diagnosis, nor did he mention coal workers' pneumoconiosis. EX 2.

The Claimant introduced two doctors' readings of the CT scan into evidence. Dr. Alexander, who is a Board-certified Radiologist and B reader, read the scan to show complicated pneumoconiosis and bullous and nonbullous emphysema. CX 15. Dr. Wiot, who is also dually certified, also read it as showing complicated pneumoconiosis. In a follow-up letter dated December 20, 2002, Dr. Wiot reiterated his diagnosis of complicated coal workers' pneumoconiosis, and said the opacities were not tuberculosis. CX 22; EX 12. However, in a deposition taken in May 2006, described below, Dr. Wiot, said he had stated this too strongly; he said he could not rule out tuberculosis, and the chances were 50-50 whether the opacities represented complicated pneumoconiosis, or tuberculosis. EX 12.

The Employer introduced additional readings of the CT scan by two Pulmonologists and two Radiologists.[5] Dr. Renn, a Pulmonologist, described masses and calcifications in the upper lung fields. He diagnosed inactive pulmonary tuberculosis and bullous emphysema. He said the Claimant did not have pneumoconiosis. EX 2. Dr. Fino, also a Pulmonologist and a B reader, said the CT scan was negative for coal workers' pneumoconiosis. EX 9. Two dually qualified Radiologists, Dr. Wheeler and Dr. Scott, said that coal workers' pneumoconiosis was "most unlikely." EX 3, 5, and 10. Dr. Scott said the irregular masses were probably healed or partially healed tuberculosis.

Newly Admitted Opinions of Dr. Wiot Based on His Readings of the X-rays and CT Scan

Dr. Jerome F. Wiot is a Board-certified Diagnostic Radiologist and a B reader. His Curriculum Vitae, CX 23, and testimony at his deposition, described below, establish that he has a long and distinguished connection with the NIOSH program to certify doctors for expertise in diagnosing black lung disease by means of x-rays, as well as many years of practice in the area. Thus, his opinions carry great weight. As noted above in the procedural history, the record was reopened in this case to admit Dr. Wiot's letter dated December 20, 2002, and his deposition taken May 18, 2006.

In his letter dated December 20, 2002, admitted as CX 31, Dr. Wiot stated:

> I reviewed my original correspondence concerning the above named patient dated 08-17-94[6] and 08-23-94.[7] Films that I reviewed at that time included chest x[-]rays dated 02-05-85, 06-23-87, 12-16-88, 12-16-88, 10-24-91, 01-04-92, 05-07-92, 01-05-94, 05-13-94 and 09-08-93, and a chest CT scan dated 05-13-04.
>
> This patient definitely shows evidence consistent with complicated coal worker's pneumoconiosis. The CT scan is the most important examination in relation to distinguishing between old pulmonary tuberculosis and complicated coal worker's pneumoconiosis. By ILO rules, I have so classified these studies as being consistent with complicated coal worker's pneumoconiosis. By ILO rules I am

[5] Two additional readings of the CT scan obtained on behalf of the Employer were never offered into evidence: one by Dr. Fishman, dated September 14, 1994, *see* the Employer's production of medical records dated October 30, 1998; and, another by Dr. Morgan, dated January 19, 1995, attached to a letter dated January 25, 1995, from counsel for the Employer.

[6] In his letter dated August 17, 1994, Dr. Wiot listed a series of x-rays he had reviewed, stating that he had observed opacities classified as 1/1 and A, the large opacities showing "slight progression between 1985 and 1994," but still "within the limits of 'A' by ILO standards." He went on to state, "[b]y ILO standards, the findings must be classified as consistent with complicated coal worker's pneumoconiosis. However, the findings could all be related to old pulmonary tuberculosis and therefore as stated in the ILO rule book, I have indicated the question, at the bottom of the classification form under other comments." The attached x-ray reading forms (for 10 x-rays) classified opacities as 1/1 and A, with "[m]ay only be old TBC" in the comment section. CX 20; Ex. 1 to Wiot deposition, EX 12.

[7] Dr. Wiot wrote two letters dated August 23, 1994, one regarding his interpretation of an x-ray taken September 8, 1993, which he read as 1/1 and A, findings compatible with complicated pneumoconiosis, and the other regarding his interpretation of the CT scan dated May 13, 1994, also finding it consistent with complicated coal worker's pneumoconiosis. CX 21 and 22; Ex. 2 and 3 to Wiot deposition, EX 12.

> also able to consider other disease processes and recorded that on my report of 08-17-94. However the CT scan shows that these findings really represent complicated coal worker's pneumoconiosis and not old pulmonary tuberculosis.

This letter is also attached as Exhibit 4 to Dr. Wiot's deposition taken May 18, 2006, EX 12.

At his deposition, Dr. Wiot testified that he is currently an Emeritus Professor of Radiology at the University of Cincinnati. His practice is limited to Diagnostic Radiology. About 90% of his work relates to radiology of the chest. He also sees CT scans, but fewer than x-rays, as they are less commonly available than x-rays. Dr. Wiot was one of the first Radiologists in the country to be designated as a B reader, and subsequently, a C reader. He was a long-time member and chairman of the task force on pneumoconiosis of the American College of Radiology, and in that capacity worked closely with NIOSH and the ILO. He has presented the B reader course to physicians wishing to take the examination, and participated in revision of the classification system. He has authored numerous publications, and served as the president of the American College of Radiology and the American Board of Radiology. Dr. Wiot had looked at 11 x-rays taken between February 1985 and May 1994 and a CT scan of the Claimant's chest taken in May 1998. Dr. Wiot testified that by looking at a series of films, he gets a better chance of seeing the course of a disease. He agreed that the sample of x-ray films he saw for the Claimant was a better than average sample.

Looking back at his readings of the Claimant's x-rays,[8] Dr. Wiot said he was ambivalent, because the opacities were "r" size opacities, which is unusual with coal workers' pneumoconiosis, as "q" and "t" are most common. He said, however, that "by ILO rules I've got no choice but to classify this as consistent with complicated coal workers' pneumoconiosis." EX 12 at 16. He raised the question of tuberculosis ("TB"), because it can look exactly like coal workers' pneumoconiosis. He said volume loss in the upper lobe is a common finding in anyone with a fibrotic process, but stranding, as seen on the Claimant's x-ray, is more related to inflammatory process. His job in reviewing the x-rays was to say whether the findings were compatible with coal workers' pneumoconiosis, and he had to say "yes," but he had concern which he made known, that it could be old TB.

After reviewing his August 1994 report on the CT scan, he said that he had to call it complicated pneumoconiosis, but he could not rule out TB. He had no clinical history when he read the films; he does not ask for it, and does not want to have it when he reads films. Asked whether it would be significant that both the Claimant's mother and brother died of TB, Dr. Wiot said he had been told about the Claimant's mother, who died when the Claimant was nine months old, but not his brother, who supposedly died of TB at age 45. Counsel for the Claimant said it was disputed whether the Claimant's brother actually died of TB, at which point, Dr. Wiot said, in essence, that there was a 50% chance that it was TB, and a 50% chance that it was coal workers' pneumoconiosis, but he could not distinguish between the two. EX 12 at 22. Dr. Wiot said it might help if he could get a few of the older films to compare to a newer film, to see what is happening to the large opacities. The other possibility would be to perform a high resolution CT to get a better look at the whole area. Based on the information now available to him, he said, "I don't really know." EX 12 at 25.

[8] As noted above, the x-ray films themselves were no longer available by the time of Dr. Wiot's deposition. Thus, he was reviewing his old reports, not re-reading the x-rays.

Asked by Claimant's counsel whether it was still his opinion that the CT scan showed that the x-ray findings represented complicated coal workers' pneumoconiosis, and not old pulmonary tuberculosis, Dr. Wiot said,

> No. The more I sit here and look at my old reports, you know, I have to admit that I feel that I'm … in a quandary as to whether it really represents TB or whether it really represents CWP [coal workers' pneumoconiosis]. I don't know why I was so strong with you, but I don't think I should have been as strong with you as I was.

EX 12 at 33. He went on to say that the best thing to do is "get a new high resolution CT, get new films and let three or four people look at them and see whether they could agree as to what was going on." EX 12 at 34. He testified that he had no choice under the ILO classification system except to call it complicated coal workers' pneumoconiosis, but he was not comfortable with it. He said he did not remember the CT, but it must have made him feel a bit more comfortable towards complicated coal workers' pneumoconiosis than TB. He said the CT scans in 1994 were better than chest x-rays, but not as good as they are today; the equipment is much better today. He said that the progression he saw between 1985 and 1994 could be compatible with either diagnosis.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006).

Dr. Green

Dr. Green, a Doctor of Osteopathy, and the Claimant's treating physician, prepared a report concerning the Claimant dated January 11, 1995. Dr. Green stated that the Claimant's x-rays were consistent with pneumoconiosis and his pulmonary function studies were consistent with chronic obstructive lung disease. Based on the Claimant's coal dust exposure, physical symptoms, and x-ray and pulmonary function studies, Dr. Green opined that the Claimant suffered from pneumoconiosis and chronic obstructive lung disease. CX 10. The Claimant submitted Dr. Green's treatment records from February 1, 1985, through October 17, 1994, in support of his report. CX 29. The records show that Dr. Green saw the Claimant on a regular basis throughout that period, a few times a year between 1985 and 1990, and more frequently from 1991 to 1994. The diagnoses of coal workers' pneumoconiosis and chronic obstructive pulmonary disease appear throughout the records, with occasional notations of exacerbation, bronchitis, or asthmatic bronchitis.

Dr. Villanueva

Dr. Villanueva examined the Claimant on behalf of the Department of Labor on July 2, 1980. DX 33 (DX 19). He took occupational, social, and family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. He reported that the Claimant worked in the mines for 32 years from 1947 to 1979. He reported a smoking history of 1½ packs per day for 40 years.[9] Dr. Villanueva read the x-ray as showing coal workers' pneumoconiosis. Chest examination revealed a slight increase in the AP diameter, and reduced breath sounds. Dr. Villanueva diagnosed coal workers' pneumoconiosis and chronic obstructive pulmonary disease. He checked boxes indicating that pneumoconiosis was related to dust exposure, but chronic obstructive pulmonary disease was not. An added comment stated, "X-ray evidence of Pneumoconiosis—No evidence of significant pulmonary dysfunction."

Dr. Zaldivar

Dr. Zaldivar examined the Claimant on behalf of the Employer on April 19, 1989, and reviewed his medical records. CX 11. Dr. Zaldivar is Board-certified in Internal Medicine, Pulmonary Disease, and Sleep Disorder Medicine, and a B reader. CX 12. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-rays, pulmonary function tests, and arterial blood gas studies. He reported that the Claimant worked in the mines for 32 years. He reported that "[the Claimant] began smoking when he was in his teens. He used to smoke one pack of cigarettes per day until approximately 1974." Dr. Zaldivar read the x-rays as showing simple and complicated pneumoconiosis. The pulmonary function test showed moderate obstruction and moderate diffusion impairment. The arterial blood gas study was normal at rest and with exercise. Based upon his examination, Dr. Zaldivar concluded that the Claimant was suffering from coal worker's pneumoconiosis. Dr. Zaldivar's findings are as follows:

1. Moderate irreversible airway obstruction.
2. No air trapping by lung volumes.
3. Moderate diffusion impairment.
4. Normal resting and exercising blood gases.
5. Abnormal electrocardiogram with ST segment changes in the lateral lead suspicious or ischemic heart disease.
6. Simple and complicated coal workers' pneumoconiosis radiographically.

He said the obstruction may be due to cigarette smoking and coal workers' pneumoconiosis. He thought the diffusion impairment together with low residual volume was due to complicated pneumoconiosis.

[9] This is the longest and heaviest smoking history reported in the record. The Claimant testified at the hearing that he smoked a pack to a pack and a half a day (on weekends when he did not work) for 32 years. Tr. at 45. His testimony at the hearing was consistent with his reports to various doctors who examined him over the years. I find that the Claimant had a 32-48 pack year smoking history ending in 1972.

Dr. Daniel

Dr. Daniel examined the Claimant on behalf of the Department of Labor on September 8, 1993. DX 13. Dr. Daniel is Board-certified in Family Practice. EX 1 to the May 1990 hearing. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. He reported that the Claimant worked in the mines for 32 years. He reported a smoking history of one pack per day for 30 years. Dr. Daniel read the x-ray as showing pneumoconiosis. The pulmonary function test showed moderate obstructive impairment. The arterial blood gas study was normal at rest and abnormal with exercise. Dr. Daniel diagnosed coal workers' pneumoconiosis (based on x-ray and caused by coal dust exposure) and chronic obstructive pulmonary disease (based on history of smoking and abnormal pulmonary function study and caused by 30 years of cigarette smoking). Dr. Daniel found that the Claimant suffered from a moderate obstructive impairment which would prevent the Claimant from performing "moderate to heavy labor." Dr. Daniel said this impairment was equally caused by the pneumoconiosis and chronic obstructive pulmonary disease.

In a letter dated September 23, 1994, responding to a query from counsel for the Employer, Dr. Daniel stated:

> In response to your letter of 9/12/94 in which you ask the question, could the problem of a moderate obstructive impairment which would prevent this individual from doing heavy manual labor, have developed since an evaluation of this individual in 1980? A repeat examination was done in 1993 which revealed the aforementioned disability. In 1980, the patient showed no evidence of respiratory impairment. He did show evidence of pneumoconiosis at that time and it should be noted that he also showed evidence of obstructive lung disease. As you know, pneumoconiosis is a progressive illness, even though the exposure to coal dust does not continue, the disease does progress. But it generally creates a restrictive defect, but can as it advances produce an obstructive defect particularly if the patient has smoked in the past. This patient apparently quit smoking 21 years ago, according to the history sheet; however, if the chronic obstructive lung disease is present at that time it can progress as does the pneumoconiosis. Therefore, even though the patient was not exposed to coal dust since 1979, these pulmonary diseases can progress even without continued etiologic exposure and can cause disability in the future.

CX 27.

Dr. Stewart

Dr. Stewart reviewed the Claimant's medical data in reports dated April 5, 1990 (EX 1 to the May 1990 hearing), October 5, 1994 (EX 5), and January 16, 1995 (EX 6). Dr. Stewart is Board-certified in Internal Medicine and Pulmonary Disease, and is a B reader.

In his first report, Dr. Stewart said that the Claimant did not suffer from coal workers' pneumoconiosis. He specifically referred to the negative x-ray readings in making that statement. He also found that the Claimant was not totally disabled from a respiratory

impairment, pointing out that the pulmonary function studies showed a mild obstruction and no restriction, and blood gas studies showed no significant hypoxemia. He diagnosed two respiratory impairments, chronic obstructive pulmonary disease from smoking cigarettes, and fibronodular densities consistent with prior fungal disease or tuberculosis, neither impairment having been caused in whole or in part by exposure to coal dust. EX 1 to the May 1990 hearing.

Dr. Stewart reviewed additional medical reports and prepared a report dated October 5, 1994. Dr. Stewart stated that it remained his opinion that the Claimant did not have coal workers' pneumoconiosis, based on negative x-ray readings, and the absence of any biopsy specimens to contradict his conclusion. He said that the pulmonary function testing ruled out any form of restrictive impairment. He said that it is possible to distinguish between impairments caused by smoking cigarettes and those caused by coal worker's pneumoconiosis, because the former causes an obstructive impairment, while the latter causes a restrictive impairment. He continued to believe that the Claimant was not totally disabled despite his moderate impairment, because he did not believe the Claimant's coal mine job as a superintendent involved strenuous work. He said it would not change his opinion if the Claimant were found to have pneumoconiosis because of his opinion that it is possible to distinguish between smoking and coal dust-induced disease. EX 5.

Dr. Stewart reviewed additional medical reports and prepared a supplemental report dated January 16, 1995. EX 6. He said he continued to be of the opinion that the Claimant did not suffer from pneumoconiosis based on additional x-ray reports and the absence of a restrictive impairment. He also opined that the Claimant was not disabled from performing occasional strenuous labor. He agreed that the Claimant had moderate chronic obstructive pulmonary disease from his history of smoking. He said that the impairment was not caused by coal workers' pneumoconiosis or coal dust exposure because the type of impairment "is not caused by coal workers' pneumoconiosis but instead is typical of patients who develop chronic obstructive pulmonary disease from smoking cigarettes." He said his opinion would not change even if the Claimant were found to have coal workers' pneumoconiosis, because "[t]the pulmonary function data would remain the same and again indicates an obstructive type impairment seen in cigarette smokers."

Dr. Renn

Dr. Renn examined the Claimant on May 13, 1994, and reviewed his medical records (EX 2), and reviewed additional medical records in a report dated January 19, 1995 (EX 7). He was deposed on February 15, 1995. EX 11. Dr. Renn is Board-certified in Internal Medicine and Pulmonary Disease, and a B reader. During his examination of the Claimant, he took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, CT scan, blood gas studies and pulmonary function testing. He diagnosed inactive pulmonary tuberculosis, and bullous emphysema with a bronchospastic component, with a moderate, significantly bronchoreversible, obstructive ventilatory defect. He attributed the impairment to bullous emphysema caused by smoking, and said it did not result from exposure to coal mine dust. He said even were the Claimant found to have coal workers' pneumoconiosis, based on the physiologic pattern, the impairment would not be from coal workers' pneumoconiosis. EX 2.

Dr. Renn's examination report stated that the Claimant worked in the mines for 32 years from 1947 to 1979. Dr. Renn stated at his deposition that the year the Claimant left the mines is significant because:

> If a person has … not developed a coal mine dust-induced disease at the time that they are no longer exposed, then they will not subsequently develop a coal mine dust-induced disease.

EX 11 at 7. He said the Claimant reported smoking one to one and one-half packages of cigarettes a day from 1941 to 1972, "an adequate amount to cause respiratory diseases, as well as other diseases, such as cardiovascular diseases and malignancies." *Ibid*. He said former smokers have an increased risk of obstructive airways diseases and respiratory tract malignancies. He said the Claimant's treatment records and medications indicate that he was being treated for obstructive airways disease. Asked whether the medications would be of any use in treating impairments associated with coal dust exposure, he said,

> There is no known treatment for coal workers' pneumoconiosis if it is still in the simple stage. There is only treatment for comorbid conditions, such as chronic bronchitis, emphysema, asthma, etcetera.

EX 11 at 13-14.

Dr. Renn attributed the Claimant's abnormal chest x-rays to old healed tuberculosis. After reviewing a series of x-rays, he did not identify any opacities consistent with pneumoconiosis. He said x-ray showed "bilateral upper lobe infiltrates and nodular densities of varying size, loss of volume of the right upper lobe and possible calcification within the nodules all consistent with old inactive pulmonary tuberculosis." The CT scan was also consistent with pulmonary tuberculosis.

The pulmonary function test showed moderate obstructive ventilatory defect. Dr. Renn said that post-bronchodilator improvement indicated a bronchospastic component to his obstructive airways disease which is not consistent with coal workers' pneumoconiosis or any coal mine dust-induced disease. He said obstructive lung disease associated with exposure to coal mine dust has been shown to have "a statistically significant reduction in volumes and flows, but not a clinically significant reduction." EX 11 at 22-23. He said there was no clinically significant obstructive disease associated with exposure to coal mine dust in studies controlled for smoking. He attributed the Claimant's abnormal diffusing capacity and hypoxemia with exercise to parenchymal disease, and a combination of emphysema and tuberculosis. EX 11 at 24, 26. He said that the emphysema caused by smoking could be seen on x-ray, but that focal emphysema of coal workers' pneumoconiosis cannot be appreciated by plain chest x-ray. EX 11 at 27.

Dr. Renn diagnosed inactive pulmonary tuberculosis, bullous emphysema with a bronchospastic component, and hypercholesterolemia and hypothyroidism. Dr. Renn opined in his report that none of these diagnoses were "caused by nor contributed to, his exposure to coal mine dust." Rather, Dr. Renn attributed the bullous emphysema to the Claimant's years of tobacco smoking rather than coal mine dust. Based upon his examination, Dr. Renn concluded that the Claimant was not suffering from coal worker's pneumoconiosis. Dr. Renn opined after

reviewing the medical data that "[the Claimant] has inactive pulmonary tuberculosis, bullous emphysema with bronchopathic component and, by past medical history, hypercholesterolemia and hypothyroidism. It remains my opinion that he does not have pneumoconiosis." Additionally, Dr. Renn opined that the Claimant has a moderate obstructive defect which is a result of the bullous emphysema. Dr. Renn further opined that the bullous emphysema was caused by tobacco smoking. Dr. Renn found that the Claimant was not totally disabled to the extent that he could not perform his last coal mining job of mine foreman or any similar work effort. At his deposition, he said he based that opinion on a lighter level of exertion than described by Dr. Rasmussen below, but he agreed that the Claimant would be unable to perform heavy exertion.

Dr. Fino

Dr. Fino, who is Board-certified in Internal Medicine and Pulmonary Diseases, reviewed the Claimant's medical data several times in reports dated November 22, 1988 (DX 33 (DX 52A)), April 5, 1989 (DX 33 (DX 59)), May 6, 1989 (EX 7), April 6, 1990 (EX 1 to the May 1990 hearing), October 3, 1994 (EX 4), and January 20, 1995 (EX 7). Dr. Fino was deposed on February 9, 1995. EX 9. In his reports, Dr. Fino opined that the Claimant had a mild obstructive respiratory impairment which he attributed to emphysema. This emphysema, Dr. Fino said, was a result of the Claimant's extensive smoking history and not coal dust exposure. In his initial report, he thought there was x-ray evidence of pneumoconiosis; however, after further review of additional x-rays, he concluded that there was no evidence of radiographic pneumoconiosis. DX 33 (DX 59). Initially he said, "[i]f no radiographic pneumoconiosis were present, then cigarette smoking would be the sole cause of his mild impairment." DX 33 (DX 52A). Once he determined that there was no radiographic evidence, he confirmed his belief that coal dust played no role in the development of the Claimant's emphysema. DX 33 (DX 59). Dr. Fino further concluded that the Claimant was not totally disabled.

Dr. Fino opined that the April 1989 x-ray showed no changes from the Claimant's previous x-rays. Dr. Fino stated "[t]he abnormalities in the upper zones were present in 1980 and are exactly the same on the chest x-ray dated 4/19/89." Dr. Fino opined that the Claimant did not suffer from complicated pneumoconiosis based the Claimant's lack of history of simple pneumoconiosis and "the stability of the lesions along the apical pleural thickening." Dr. Fino also opined that the abnormalities of the Claimant's April 1989 pulmonary function study were due to the Claimant's cigarette smoking.

In his October 1994 report, based on the two examinations on behalf of the Department of Labor in 1980 and 1993, and Dr. Renn's examination in 1994, Dr. Fino said the Claimant's decline in pulmonary function since 1980 was slightly greater than would be expected with aging, and could be explained by the Claimant's pulmonary emphysema including bullous emphysema. He said the obstructive abnormality along with the reduction in diffusing capacity and mild impairment in oxygen transfer were consistent with emphysema, and not related to the inhalation of coal dust. EX 4.

In Dr. Fino's January 20, 1995, report, he attributed the obstructive abnormality noted by Drs. Renn and Rasmussen to bullous emphysema and cigarette smoking. Dr. Fino reiterated that the Claimant did not suffer from complicated coal workers' pneumoconiosis. Dr. Fino opined

that if the Claimant would be unable to perform considerable heavy lifting or heavy labor. Dr. Fino noted that this inability is not related to the inhalation of coal dust. EX 7.

At his deposition, Dr. Fino explained why he did not believe the abnormalities seen on the Claimant's x-rays and CT scan represented simple or complicated pneumoconiosis. He said that the changes he observed "do not look like the typical changes of simple or complicated pneumoconiosis which I see in my practice, [and] they are not consistent with what has been described in the medical literature …." EX 9 at 10. *See also,* EX 9 at 29. Dr. Fino agreed with Dr. Rasmussen's report that the CT scan suggested primarily a granulomatous disease such as tuberculosis, fungus, or sarcoid disease. He said the pattern of studies showing broncho-reversible obstructive airways disease with normal lung volumes, a moderate to severely decreased diffusing capacity, normal resting blood gases and decreased exercise blood gases suggest "an obstructive type abnormality with bullous emphysema accounting for the reduction in diffusion." Bullous emphysema was observable on the CT scans. He said it is possible that granulomatous disease was not causing the Claimant's impairment, despite its prominence in x-rays. He would not attribute any of the Claimant's impairment to coal dust exposure.

Dr. Fino said that over time, the spirometry revealed a change in the Claimant's condition; there was more obstruction in later studies. Medications prescribed for the Claimant would improve his breathing if there was some reversible narrowing of his airways, but are not an effective tool to use to treat impairments associated with coal mine dust-induced lung disease, "because in coal workers' pneumoconiosis the abnormality is a fixed fibrotic condition not involving the breathing tubes." EX 9 at 21-22. *See also,* EX 9 at 30-31. The 18% reversibility of the Claimant's obstruction on administration of bronchodilators in Dr. Renn's 1994 study suggested that the Claimant had asthma, in view of the fact that he quit smoking in 1972. Spirometry by Dr. Rasmussen in 1994 achieved similar results to Dr. Renn's studies. The results of spirometry and blood gas studies indicated that the Claimant would be unable to perform heavy and very heavy manual labor repeatedly.

Dr. Fino testified that he did not find the medical literature cited by Dr. Rasmussen to be convincing scientific proof of an obstructive lung disease associated with coal dust exposure. He said that "working miners may have very mild reductions in the FEV_1 as a result of the inhalation of coal mine dust and, in fact, when you stop working that should go away and there is nobody – not studies in the literature that suggest that it persists." EX 9 at 33. Dr. Fino went on to cite to studies indicating that miners had no "significant" obstruction arising out of coal mine dust exposure.

Dr. Loudon

Dr. Loudon reviewed the Claimant's medical data in a report dated January 22, 1995. EX 7. Dr. Loudon is a Professor and Director of the Pulmonary Disease Division of the University of Cincinnati Medical Center. He reviewed medical reports, x-rays, pulmonary function studies, arterial blood gas studies, and DOL filings. Dr. Loudon opined that the Claimant did not suffer from coal workers' pneumoconiosis. He said he based his opinion "on the absence of x-ray evidence of pneumoconiosis, and on the pulmonary function test and clinical findings which are consistent with obstructive lung disease." Dr. Loudon found that the Claimant had a mild degree of pulmonary or respiratory impairment, which he attributed to chronic obstructive lung disease, chronic bronchitis, and emphysema. He said that coal workers'

pneumoconiosis was not implicated in the impairment. Dr. Loudon opined that the Claimant was not totally and permanently disabled from the respiratory or pulmonary viewpoint to the extent that he would be unable to do his regular coal mining work or work requiring similar effort. He said the mild disability was not caused either in whole or in part by pneumoconiosis. He said his opinion on the cause of the impairment would not change if the Claimant were found to have coal workers' pneumoconiosis, "based on the nature of the claimant's symptoms and signs, and on the pulmonary function test results showing a partly reversible obstructive impairment, not found in CWP."

Dr. Crisalli

Dr. Crisalli examined the Claimant on August 14, 1987 (DX 33 (DX 46)), and reviewed his medical records in reports dated April 6, 1990 (EX 1), December 22, 1994 (EX 5), and January 24, 1995 (EX 8). Dr. Crisalli is Board-certified in Internal Medicine and Pulmonary Diseases. During the physical examination, he took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. He reported that the Claimant worked in the mines for 32 years. He reported that the Claimant was a "heavy smoker" up until 1972 when he quit. The chest examination revealed coal workers' pneumoconiosis (2/1 p/q). The pulmonary function test showed mild obstructive and mild restrictive impairment. The arterial blood gas study was normal at rest and with exercise. Dr. Crisalli diagnosed coal workers' pneumoconiosis, based in part on radiographic evidence. Dr. Crisalli opined that the Claimant suffered from a respiratory impairment, including a mild obstructive defect due primarily to his history of heavy smoking, "but there may also be a component secondary to coal dust exposure." He said there was also a mild restrictive defect most likely related to coal dust exposure, correlating with the coalescence of nodules seen on x-ray. He said the Claimant has a 10% pulmonary function impairment. DX 33 (DX 46).

In his December 22, 1994, report, Dr. Crisalli opined that the Claimant did not suffer from coal workers' pneumoconiosis. He said he changed his opinion "due to the massive amount of x-ray data including CT scans which indicates that there is no occupational pneumoconiosis present." He diagnosed a mild pulmonary impairment "secondary to [the Claimant's] bullous emphysema and hyperreactive airways disease which undoubtedly have resulted from his tobacco smoking over the years." Dr. Crisalli did not find the Claimant to be totally disabled or unable to perform his previous coal mining job. EX 5.

Dr. Crisalli reviewed additional medical data, including recent reports from Drs. Fino, Rasmussen, and Stewart, and CT scan and x-ray interpretations by Drs. Scott and Wheeler. In his January 24, 1995, report, he said that there was not sufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis. He said the Claimant's impairment of pulmonary function "must" be attributed to old tuberculosis, bullous emphysema, and hyperreactive airways disease. He said he could not answer whether his opinion regarding the degree and cause of impairment if the Claimant were actually found to have coal workers' pneumoconiosis, "since in fact [the Claimant] does not have coal worker's pneumoconiosis." He said the Claimant's pulmonary function had declined between 1980 and 1995 to a slightly greater degree than would be expected with age; the degree of drop was "easily explained based on age and the patient's bullous emphysema." EX 8.

Dr. Rasmussen

Dr. Rasmussen examined the Claimant on September 19, 1994 (CX 7), and reviewed his medical records in reports dated January 12, 1995 (CX 8), January 25, 1995 (CX 13), and January 26, 1995 (CX 14). Dr. Rasmussen is Board-certified in Internal Medicine and a B reader. He served on black lung medical advisory committees for NIOSH and the United Mine Workers of America. CX 9. During the 1994 examination, Dr. Rasmussen took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. He reported that the Claimant worked in the mines for 32 years. He reported a smoking history of one and one-half packs per day for 26 years. The chest examination revealed reduced breath sounds. Dr. Rasmussen concluded that the Claimant suffered from complicated pneumoconiosis based on the x-ray evidence and coal mine employment. The pulmonary function test showed moderate, partially reversible obstructive impairment. The arterial blood gas study was normal. Dr. Rasmussen found that the Claimant had a "moderately severe loss of respiratory function," and this degree of impairment would render the Claimant totally disabled for resuming his former coal mine job, which included heavy and very heavy manual labor. He stated that there were "two obvious risk factors for the patient's disabling respiratory insufficiency. These include his coal mine dust exposure and his cigarette smoking. His coal mine dust exposure must be considered at least a major contributing factor. CX 7.

After reviewing the Claimant's medical data, Dr. Rasmussen opined, as in his earlier report, "that [the Claimant] suffers from coalworkers' pneumoconiosis which arose from his coal mine employment and which was a major contributing factor to his totally disabling respiratory insufficiency." Dr. Rasmussen opined that the Claimant was totally disabled for performing heavy manual labor, "which was certainly required at his job, according to the history provided to me." Dr. Rasmussen observed that most of the x-rays were read as negative, and the CT scan suggested "primarily a granulomatous disease rather than complicated pneumoconiosis." Nonetheless he said he could not exclude the presence coal workers' pneumoconiosis, or an effect of coal mine dust exposure on the Claimant's condition. He stated that "[t]here is a large body of evidence confirming the fact that coal mine dust exposure is quite capable of producing disabling chronic obstructive lung disease including pulmonary emphysema." Dr. Rasmussen concluded that "it is not possible to separate the effects of cigarette smoking from that of coal mine dust exposure. Therefore, I disagree with the opinions of Drs. Renn, Stewart, Fino and Crisalli." Dr. Rasmussen diagnosed chronic lung disease caused by the Claimant's cigarette smoking and coal dust exposure. CX 8.

In his report dated January 25, 1995, Dr. Rasmussen criticized Dr. Stewart for implying that pneumoconiosis produces restrictive pulmonary disease, observing that obstructive lung disease has been shown to be caused by coal mine dust exposure. He also criticized Dr. Stewart's conclusion that the Claimant retained the pulmonary capacity to resume his last coal mine employment, noting the very marked reduction in diffusion capacity. He reiterated his opinion that the Claimant suffered from pneumoconiosis, arising from his coal mine employment, and a major contributing factor to his totally disabling respiratory insufficiency. CX 13.

In his letter dated January 26, 1995, Dr. Rasmussen criticized Drs. Renn, Loudon, and Fino for ignoring a large body of evidence indicating that coal dust exposure can produce

chronic airway obstruction "which is indistinguishable from that produced by cigarette smoking, and that the presence of obstructive lung disease and … a pattern of airway obstruction in no way excludes coal mine dust exposure as a cause of the impairment." CX 14.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Twenty CFR § 718.201 (2006). In this case, the Claimant's medical records indicate that he has been diagnosed with chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. *Ibid*.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003); 65 Fed. Reg. 79938 (2000) ("[t]he Department reiterates … that the revised definition does not alter the former regulations' … requirement that each miner bear the burden of proving that his obstructive lung disease did in fact arise out of his coal mine employment, and not from another source.").

As noted above, pursuant to 20 CFR § 718.202(a) (2006), I must consider the x-ray evidence and medical opinion evidence, including opinions regarding the CT scan, to determine whether the Claimant has established the existence of pneumoconiosis. As the evidence is conflicting, in accordance with *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000), and the instructions of the BRB, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has clinical or legal pneumoconiosis.

The Board affirmed Judge Kichuk's finding that the x-ray evidence before him was not sufficient to establish the existence of clinical pneumoconiosis. The new evidence from Dr. Wiot underscores the correctness of that finding as Dr. Wiot testified, in essence, that he erred in his December 20, 2002, letter by giving too strong an opinion that the findings on x-ray and CT scan supported a diagnosis of pneumoconiosis, but not tuberculosis. Rather, he said during his deposition, there was a 50-50 chance that the opacities were the result of either disease. As the Claimant relied heavily on Dr. Wiot's positive x-ray readings, most of which also mentioned the possibility of tuberculosis, Dr. Wiot's testimony undermines the Claimant's case for establishing a finding of clinical pneumoconiosis based on x-ray or the CT scan. Indeed, because Dr. Wiot's positive x-ray readings are made equivocal by his deposition testimony, under the current state of the evidence, all 14 x-rays and the CT scan could be viewed as either negative, or at best, in equipoise. The rules specifically provide, however, that benefits cannot be denied based on a negative x-ray reading. 20 CFR § 718.202(b). Moreover, I note that Dr. Wiot is preeminent in this field, and his assessment of a 50-50 chance that the markings seen on x-ray and the CT scan are evidence that the Claimant has pneumoconiosis, means that the presence of clinical pneumoconiosis has not been ruled out by the x-ray and CT scan evidence.

Dr. Wiot's deposition testimony also supports Judge Kichuk's and the Board's conclusion that the Claimant failed to establish that he has complicated pneumoconiosis, thus making inapplicable the presumption of total disability due to pneumoconiosis in cases of complicated pneumoconiosis. It follows that the Claimant must rely on medical opinion evidence as to whether he has pneumoconiosis if he is to prevail in this case.

The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the Judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

The Department's position underlying the amended regulations, stated in the commentary that accompanied the issuance of the current regulations, is that coal dust exposure may induce obstructive lung disease even in the absence of fibrosis or complicated pneumoconiosis. The Department concluded that "[e]ven in the absence of smoking, coal mine dust exposure is clearly associated with clinically significant airways obstruction and chronic bronchitis. **The risk is additive with cigarette smoking**." 65 Fed. Reg. at 79940 (emphasis added). Citing to studies and medical literature reviews conducted by NIOSH, the Department quoted the following from NIOSH:

> … COPD may be detected from decrements in certain measures of lung function, especially FEV1 and the ratio of FEV1/FVC. **Decrements in lung function associated with exposure to coal mine dust are severe enough to be disabling in some miners, whether or not pneumoconiosis is also present**.…

Sixty-five Fed. Reg. at 79943 (emphasis added). Moreover, the Department concluded that the medical literature "support[s] the theory that dust-induced emphysema and smoke-induced emphysema occur through similar mechanisms." Medical opinions which are based on the premise that coal dust-related obstructive disease is completely distinct from smoking-related disease, or that it is never clinically significant, are, therefore, contrary to the premises underlying the regulations. I have considered how to weigh the conflicting medical opinions in this case based on these principles.

Dr. Green was the Claimant's treating physician for at least 10 years. He has no documented credentials in Pulmonology. His records show that he consistently treated the Claimant for pneumoconiosis and chronic obstructive pulmonary disease, and he attested to both diagnoses in his 1995 report. As the Claimant's treating physician, his opinion is entitled to considerable weight, at least as to the condition of the Claimant's lungs. Nonetheless, there is no evidence that he has seen the negative x-ray readings or any interpretations of the CT scan, which was requested by one of the Employer's experts; neither his records nor his report distinguish between clinical and legal pneumoconiosis; and, nowhere does he offer an opinion whether coal dust exposure contributed to the Claimant's well-documented obstructive impairment. For these reasons, the weight to which his opinion is entitled is diminished.

Dr. Villanueva examined the Claimant on behalf of the Department of Labor in 1980. His qualifications are not in the record. Dr. Villanueva found the Claimant to suffer from clinical pneumoconiosis based on a positive x-ray reading. He also found the Claimant to be suffering from chronic obstructive pulmonary disease, but indicated by checking a box that it was caused only by smoking. He did not offer any explanation of that conclusion. There was no evidence of pulmonary dysfunction at the time of his examination in 1980. I cannot determine whether he has any special qualifications, or the basis for his conclusion that coal dust exposure did not contribute to the Claimant's chronic obstructive pulmonary disease. Moreover, his opinion was remote in time. For all of these reasons, I give it little weight.

Dr. Zaldivar examined the Claimant in 1989 and reviewed his medical records, on behalf of the Employer. He is a Board-certified Pulmonologist and a B reader. He diagnosed both legal and clinical pneumoconiosis. His opinion is notable for its objectivity, as he was retained by the Employer. Although I have determined that ultimately, the weight of the x-ray evidence does not support a finding of clinical pneumoconiosis, neither does it rule it out. As Dr. Zaldivar had considerable data available to him which supported his views, his opinion was both well documented and well reasoned. I give probative weight to his opinion on both issues of clinical and legal pneumoconiosis.

Dr. Daniel examined the Claimant on behalf of the Department of Labor in 1993. Dr. Daniel is a family doctor. His opinion was based on the histories given him by the Claimant, physical examination, and testing. His opinion was well supported by the limited amount of information available to him. However, his initial report was internally inconsistent, as he said at one point that the Claimant's chronic obstructive pulmonary disease was caused only by smoking, but at another point that the Claimant's obstructive impairment was equally caused by pneumoconiosis and chronic obstructive pulmonary disease. Later, in a response to a query from the Employer, Dr. Daniel explained that pneumoconiosis is progressive and generally creates a restrictive defect but can as it advances produce an obstructive defect, particularly if the patient has smoked in the past, as did the Claimant. I find that Dr. Daniel found that the Claimant had both clinical and legal pneumoconiosis, and that both contributed to his obstructive impairment. Although Dr. Daniel has lesser qualifications than the Pulmonologists, his opinion is entitled to some probative weight.

Dr. Stewart reviewed the Claimant's medical data several times and provided several reports between 1990 and 1995. He is a Board-certified Pulmonologist and a B reader. Dr. Stewart opined that the Claimant did not suffer from pneumoconiosis based on negative x-ray readings. He diagnosed chronic obstructive pulmonary disease from smoking, and said the findings on x-ray represented fibronodular densities consistent with prior fungal disease or tuberculosis. In the third remand, the BRB said that it agreed with the Director, OWCP, that:

> … none of the physicians on whom employer relies, Drs. Fino, Renn, Stewart and Crisalli, opined that coal dust could not cause an obstructive lung disease. Thus, their opinions cannot be discredited under the standard in *Stiltner v. Island Creek Coal Co.*, 8[6] F.3d 337, 20 BLR 2-246 (4th Cir. 1996)."

Decision and Order at 7. However, Dr. Stewart stated repeatedly that the obstructive impairment demonstrated on the Claimant's pulmonary function tests (a reduced FEV_1/FVC ratio) is not seen in patients with pneumoconiosis, which causes restrictive disease. Thus, I respectfully disagree

with the conclusion that Dr. Stewart did not opine that pneumoconiosis could not cause an obstructive disease. At the very least, his reports read as a whole indicate that Dr. Stewart did not consider whether the Claimant has legal, as opposed to clinical, pneumoconiosis. His opinion that the Claimant does not have clinical pneumoconiosis is documented and reasoned, and, therefore, entitled to probative weight on that issue. As I find he did not consider the possibility of legal pneumoconiosis, however, his opinion is not entitled to probative weight on that issue.

Dr. Renn examined the Claimant and reviewed his medical records in 1994, and reviewed additional medical records twice in 1995. Dr. Renn is also a Board-certified Pulmonologist and a B reader. He found that the Claimant did not suffer from pneumoconiosis, and said even if he did, his impairment was due entirely to smoking. Dr. Renn opined that the Claimant suffered from emphysema due to his extensive smoking history. Dr. Renn's view that the Claimant did not suffer from clinical pneumoconiosis is supported by evidence in the record. I infer from his reports and deposition, however, that Dr. Renn considered only clinical pneumoconiosis. He offered no explanation why coal dust did not have an additive effect to any impairment caused by smoking; his attribution of the entire impairment to smoking was conclusory. In addition, Dr. Renn made several statements at odds with the premises behind the Department of Labor regulations. For example, he said in his deposition that miners will not develop coal dust-induced disease after they leave the mines unless they have already developed it while still working in the mines. He also said that coal dust-induced obstructive disease does not produce clinically significant reductions in lung volumes and flows. In any event, as he made no assessment as to legal pneumoconiosis, his opinion cannot be considered on that issue.

Dr. Fino reviewed the Claimant's medical records on several occasions between 1988 and 1995. He, too, is a Board-certified Pulmonologist and a B reader. Dr. Fino initially diagnosed pneumoconiosis based on positive x-rays, but later concluded that the negative x-ray evidence outweighed the positive. He diagnosed emphysema due to the Claimant's extensive smoking history. He thought the abnormalities on x-rays and the CT scan suggested a granulomatous disease such as tuberculosis, fungus, or sarcoid disease. He said that the Claimant's decline in pulmonary function over the years, along with reduced diffusing capacity and mild impairment in oxygen transfer, were due to emphysema, and not related to coal dust exposure. He said reversibility of the obstructive impairment upon administration of bronchodilators went against a diagnosis of pneumoconiosis, because pneumoconiosis causes a fixed fibrotic condition that is not reversible. This and other comments suggest that Dr. Fino's opinions were focused on the presence of clinical pneumoconiosis. Moreover, Dr. Fino testified that he did not believe that the medical literature supported the conclusion that obstructive lung disease is associated with coal dust exposure. He did not believe that any reduction in the FEV_1 would persist after leaving the mines. Like Dr. Renn, he did not believe that miners could have significant obstructive disease arising out of coal dust exposure. Dr. Fino made similar arguments when the Department of Labor was considering the new regulations; his positions were specifically rejected as being against the weight of accepted medical views in the commentary to the new regulations. *See* 65 Fed. Reg. 79938-79943 (2000), *passim*. Thus, although Dr. Fino did not say outright that coal dust exposure cannot cause obstructive disease, I find that his view that it cannot cause clinically significant obstruction is inconsistent with the premises underlying the statute and the regulations. Hence I give his opinion on legal pneumoconiosis little weight. His opinion on the existence of clinical pneumoconiosis was documented and reasoned.

Dr. Loudon reviewed the Claimant's medical reports and found that the Claimant did not suffer from pneumoconiosis. Dr. Loudon is a Professor in Pulmonology at the University of Cincinnati. He said he based his diagnosis on the x-ray evidence, along with the findings consistent with partially reversible obstructive lung disease, which he said is not found in coal workers' pneumoconiosis. Reading his report as a whole, I find that Dr. Loudon's diagnosis was focused on the presence or absence of clinical pneumoconiosis. His opinion on clinical pneumoconiosis is well documented and well reasoned. Thus, I accord Dr. Loudon's report probative weight on the issue of clinical pneumoconiosis. However, Dr. Loudon also found that the Claimant suffered from chronic lung disease, chronic bronchitis, and emphysema, but failed to state an etiology for these chronic lung disorders. As he did not address the cause, I find that his opinion cannot be considered on the issue of legal pneumoconiosis.

Dr. Crisalli initially examined the Claimant on August 14, 1987. Dr. Crisalli is a Pulmonologist. At the time of his examination, Dr. Crisalli diagnosed the Claimant with pneumoconiosis based on several x-rays and pulmonary function studies. He identified coal dust as a possible contributor to the Claimant's obstructive impairment. In December 1994 and January 1995, however, Dr. Crisalli reviewed additional medical data and found that the Claimant did not suffer from pneumoconiosis. Dr. Crisalli explained that his opinion changed based on the massive amount of additional x-ray information and CT scan. He said the Claimant's impairment must be attributed to old tuberculosis, bullous emphysema, and hyperreactive airways disease due to smoking. Dr. Crisalli did not explain why he excluded coal dust as a contributing factor to the Claimant's obstructive pulmonary impairment once he decided that the x-ray evidence and CT scan did not support the diagnosis of clinical pneumoconiosis. Taken as a whole, his reports demonstrate that he addressed only whether the Claimant had clinical pneumoconiosis. His opinion on that issue was well documented and reasoned and entitled to probative weight. As he did not address legal pneumoconiosis, I cannot give his opinion weight on that issue.

Dr. Rasmussen examined the Claimant in September 1994, and reviewed his medical data on several occasions in 1994 and 1995. Dr. Rasmussen is Board-certified in Internal Medicine, and is a B reader, and has served on black lung medical advisory committees. Dr. Rasmussen diagnosed the Claimant with both clinical and legal pneumoconiosis. Initially, Dr. Rasmussen diagnosed the Claimant with complicated pneumoconiosis. Dr. Rasmussen based his diagnosis on x-ray evidence, pulmonary function studies, coal mine employment history, coal dust exposure, and other objective medical data. However, in later reports, he retracted the diagnosis of complicated pneumoconiosis because the CT scan suggested granulomatous disease rather than complicated pneumoconiosis. Nonetheless, Dr. Rasmussen consistently diagnosed the Claimant with disabling obstructive lung disease, which he attributed to both cigarette smoking and coal dust exposure. He further opined that it is impossible to separate the effects of these risk factors, reciting medical literature to support his position. Dr. Rasmussen's position is consistent with the position taken by the Department of Labor as to the import of the medical literature. It is also supported by the medical data. Thus, Dr. Rasmussen's diagnosis of legal pneumoconiosis is well-documented and well-reasoned, as is his conclusion that the Claimant does not have clinical pneumoconiosis. Thus, I afford his opinion on both clinical and legal pneumoconiosis probative weight.

Considering all of the evidence in the record regarding clinical pneumoconiosis, including the x-rays, CT scan, and medical opinion evidence, I find that the Claimant has failed to establish that he has clinical pneumoconiosis. Giving the greatest weight to Dr. Wiot's opinions, the x-ray and CT scan readings are inconclusive. As to the medical opinions, Dr. Green, Dr. Villanueva, Dr. Zaldivar, and Dr. Daniel have expressed the opinion that the Claimant suffers from clinical pneumoconiosis. Despite his long treating relationship with the Claimant, however, Dr. Green has not had access to the negative x-ray and CT scan readings, or the ambivalent readings by Dr. Wiot. Nor was Dr. Green asked to assess the suggestion that the findings on x-ray and CT scan may have represented old tuberculosis or some other disease. Dr. Green, Dr. Villanueva, and Dr. Daniel do not have the specialist credentials possessed by the other doctors who gave opinions. Dr. Zaldivar does have special credentials, and gave a well-reasoned, well-documented opinion based on the information available to him at the time, but considerable evidence was obtained after 1989, to which he did not have access when he gave his opinion. Arrayed against the positive opinions are those of Dr. Stewart, Dr. Renn, Dr. Fino, Dr. Loudon, Dr. Crisalli, and Dr. Rasmussen, that the Claimant does not have clinical pneumoconiosis. All of these physicians have special credentials relevant to diagnosing pneumoconiosis. All had access to a greater quantity and more recent evidence regarding the Claimant's medical condition. I find that the weight of the evidence does not support a finding of clinical pneumoconiosis.

The picture is very different with respect to the presence of legal pneumoconiosis. Of the doctors who addressed whether coal dust contributed to the Claimant's obstructive disease, Drs. Zaldivar, Daniel, and Rasmussen said that it did, while Drs. Villanueva and Fino said that it did not. Drs. Stewart, Renn, and Crisalli said that smoking caused the Claimant's obstructive disease, without referring to coal dust exposure at all. Dr. Green and Dr. Loudon did not address whether coal dust (*i.e.*, legal as opposed to clinical pneumoconiosis) contributed to the obstructive impairment. The BRB affirmed Judge Kichuk's finding, and I agree, that the Claimant has disabling chronic obstructive pulmonary disease. The question is whether his exposure to coal dust contributed to it. As Dr. Rasmussen noted, smoking and coal dust exposure are both risk factors for obstructive lung disease. The Claimant stopped smoking in 1972, about seven years before he left the mines in 1979. None of the physicians who attributed the Claimant's obstructive disease to smoking alone (including Drs. Stewart, Renn, and Crisalli, as well as Dr. Villanueva and Dr. Fino) addressed this point. Their failure to do so, coupled with the complete dismissal of any effects from coal dust by some, lead me to the conclusion that their opinions are less than objective. I find that the opinions of Dr. Zaldivar and Dr. Rasmussen, both of whom possess excellent qualifications, are more balanced, objective, and consistent with the medical evidence as a whole, and are, therefore, entitled to greater weight than the opinions of doctors who dismissed any role for coal dust exposure in the Claimant's obstructive disease. Dr. Daniel's opinion also supports the finding of legal pneumoconiosis, although I have given his opinion less weight due to his lesser qualifications, and some internal contradictions in his reports. Based on my weighing of all of the relevant evidence, I find that the Claimant has established that he has legal pneumoconiosis.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for 10 or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2006). The Claimant was

employed as a miner for at least 30 years, and therefore, is entitled to the presumption. The Employer has not offered evidence sufficient to rebut the presumption. Recently the 10th Circuit Court of Appeals held that the presumption applies only when the miner has established that he has clinical pneumoconiosis. *Anderson v. Director, OWCP*, 455 F.3d 1102 (10th Cir. 2006). In this case, I have found that the Claimant has established that he has legal, but not clinical, pneumoconiosis. I also find that he has established a causal relationship between his obstructive disease and his coal mine employment through the opinions of Dr. Rasmussen and Dr. Zaldivar.

Causation of Total Disability

The BRB affirmed Judge Kichuk's finding that the Claimant had established that he has a totally disabling pulmonary or respiratory impairment. In order to be entitled to benefits, the Claimant must also establish that pneumoconiosis is a "substantially contributing cause" to his disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2006); *Hobbs v. Clinchfield Coal Co*., 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co*., 914 F.2d 35, 38 (4th Cir. 1990).

The current regulations state that unless otherwise provided, the burden of proving a fact rests with the party making the allegation. 20 CFR § 725.103. The Benefits Review Board has held that § 718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). Nothing in the commentary to the new rules suggests that this burden has changed; indeed, some language in the commentary indicates it has not changed. See 65 Fed. Reg. at 79923 (2000) ("[t]hus, a miner has established that his pneumoconiosis is a substantially contributing cause of his disability if it either has a material adverse effect on his respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment …"). The Fourth Circuit requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Hobbs v. Clinchfield Coal Co*., 917 F. 2d 790, 791-792 (4th Cir. 1990). In *Toler v. Eastern Associated Coal Co*., 43 F.3d 109 (4th Cir. 1995), the Court found it "difficult to understand" how an Administrative Law Judge (ALJ), who finds that the claimant has established the existence of pneumoconiosis, could also find that his disability is not due to pneumoconiosis on the strength of the medical opinions of doctors who had concluded that the claimant did not have pneumoconiosis. The Court noted that there was no case law directly in point and stated that it need not decide whether such opinions are "wholly lacking in probative value." However the Court went on to hold:

> Clearly though, such opinions can carry little weight. At the very least, an ALJ who has found (or has assumed arguendo) that a claimant suffers from pneumoconiosis and has a total pulmonary disability may not credit a medical opinion that the former did not cause the latter unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability does not rest upon her disagreement with the ALJ's finding as to either or both of the predicates in the causal chain.

Forty-three F.3d at 116. *See also, Scott v. Mason Coal Company*, 289 F.3d 263, 269-270 (4th Cir. 2002).

Dr. Rasmussen, Dr. Zaldivar, and Dr. Daniel have attributed the Claimant's obstructive impairment to the combined effects of smoking and exposure to coal dust. All of the other physicians who have expressed an opinion blame the Claimant's obstructive pulmonary condition on his cigarette smoking alone. None of those doctors offered persuasive reasons for concluding that their judgment on the question of the cause of the Claimant's disability did not rest upon their disagreement with my finding that the Claimant has legal pneumoconiosis, or indeed, any persuasive reason for excluding coal dust as having any role. This Claimant has given a consistent history of 32 years of smoking a pack to 1½ packs of cigarettes per day. But he has also given a consistent history of having stopped smoking in 1972, or at the latest 1974, and no one challenges this history. This means that he stopped smoking approximately four to seven years before he stopped mining. I find it disturbing that the Employer's experts have not addressed these facts. Indeed they have completely failed to acknowledge or consider the fact that the Claimant stopped smoking many years ago. Their failure to do so, coupled with their complete dismissal of any effects from exposure to coal dust, lead me to the conclusion that their opinions are less than objective. Accordingly, I assign less weight to their opinions than I do to Dr. Rasmussen's and Dr. Zaldivar's. I find that coal dust exposure was a substantially contributing cause to the Claimant's pulmonary disability.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Medical evidence of total disability does not establish the date of entitlement; rather, it shows that a claimant became disabled at some earlier date. *Owens v. Jewell Smokeless Coal Corp.*, 14 BLR 1-47, 1-50 (1990). Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed, unless the evidence establishes that the miner was not totally disabled due to pneumoconiosis at any subsequent time. 20 CFR § 725.503(b) (2006); *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-___, BRB No. 04-0812 BLA (Jan. 27, 2006), slip op. at 17.

In ruling on the initial claim, Judge Chao found that the Claimant was not disabled. Judge Chao's Decision became final one year after the District Director denied the Claimant's request for modification, *i.e.*, October 1992. When he was examined by Dr. Zaldivar in 1989, he was diagnosed with complicated pneumoconiosis, which would bring him within the presumption of total disability. However, Dr. Zaldivar's report was not introduced into the record before Judge Chao, and I have found that the evidence does not support a finding of complicated pneumoconiosis. In any event, besides his diagnosis of complicated pneumoconiosis, Dr. Zaldivar stated only that the Claimant had a "moderate" impairment, but did not state whether he retained the capacity to perform his previous job in the mines or a comparable job in a dust-free environment. Thus, Dr. Zaldivar's report does not support a finding of total disability by 1989. Dr. Fino opined that the Claimant was not disabled in his early reports. Dr. Green did not express any opinion whether the Claimant was disabled by his pulmonary impairment.

The Claimant filed his duplicate claim for benefits in July 1993. By the time he was examined by Dr. Daniel in September 1993, Dr. Daniel said he was already unable to perform moderate to heavy labor. It is the law of the case that the Claimant's work required heavy to very heavy labor. Thus, Dr. Daniel's statement is equivalent to a finding of disability.

Thereafter, the only doctors who said the Claimant was not disabled, Dr. Stewart, Dr. Renn (who later agreed at his deposition that the Claimant would be unable to perform heavy exertion), Dr. Loudon, and Dr. Crisalli, were under the misapprehension that the Claimant's job did not require strenuous work. By 1994, Dr. Fino also agreed that the Claimant was disabled for heavy work.

The Claimant was found by a doctor to be disabled within a few months of filing his claim. There was no time thereafter that he was not disabled for heavy work such as he performed in his last job in the mines. I find that the Claimant is entitled to benefits commencing in July 1993, the month in which he filed his claim.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Having considered all of the relevant evidence, I find that the Claimant has established that he has legal pneumoconiosis arising out of his coal mine employment, and a totally disabling pulmonary or respiratory impairment caused by pneumoconiosis. Thus, the Claimant has met his burden of showing a material change in conditions pursuant to § 725.309(d) (2000), and that he is totally disabled due to pneumoconiosis within the meaning of the Act and the regulations. Accordingly, the Claimant is entitled to benefits under the Act.

ATTORNEY FEES

The regulations address attorney's fees at 20 CFR §§ 725.362, .365, and .366 (2006). The Claimant's attorney has not yet filed an application for attorney's fees. The Claimant's attorney is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The other parties shall have ten (10) days following service of the application within which to file any objections, plus five (5) days for service by mail, for a total of fifteen (15) days. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by the Claimant on July 27, 1993, is hereby GRANTED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C., 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail

and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, D.C., 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).